Melissa Haas
Central Registrar
mhaas@bethlehemschools.org

BETHLEHEM Central School District

http://www.bethlehemschools.org

ACADEMICS | CHARACTER | COMMUNITY | WELLNESS

Dear Parents:

Welcome to Bethlehem Central School District. Enclosed are the registration forms to be filled out completely and neatly. Along with the forms enclosed, please bring the following documentation when registering your child, to Central Registration located at 700 Delaware Avenue, Delmar, NY 12054:

- **Proof of Residency**

  - A copy of a resident lease or proof of ownership of a house or condominium, such as a deed or mortgage statement; or
  - A statement by a third-party landlord, owner or tenant from whom the parent or person in a parental relationship leases or with whom they share property within the District, which may be sworn or unsworn; or
  - Such other statement by a third party relating to the parent or person in parental relation's physical presence in the District; or
  - Other forms of documentation and/or information establishing physical presence in the District which may include but are not limited to:
    - Pay stub;
    - Income tax form;
    - Utility or other bills;
    - Homeowners, renters or auto insurance;
    - Voter registration document(s);
    - Official driver's license, learner's permit or non-driver identification;
    - State or other government issued identification; or
    - Documents issued by federal, state or local agencies (e.g., local social service agency, Federal Office of Resettlement).

Educational Services Center
700 Delaware Avenue
Delmar, NY 12054

518-439-2442
518-475-0352 fax

- **Proof of Age**

  - A certified transcript of a birth certificate; or

  - A record of baptism confirming the date of birth for the child to be enrolled in the District (a foreign birth certificate of record of baptism will also be accepted).

If a certified transcript of a birth certificate or a record of baptism is not available, please submit a copy of the child's passport. A foreign passport will be accepted.

In the event you cannot provide a passport, the District will consider an executed written affidavit of the child's age or any of the following documents as long as it was issued two or more years ago:

1. Official driver's license;
2. State or other government issued identification;
3. School photo identification with date of birth;
4. Consulate identification card;
5. Hospital or health records;
6. Military dependent identification card;
7. Documents issued by federal, state or local agencies, such as local social service agency or federal Office of Refugee Resettlement;
8. Court orders or other court-issued documents;
9. Native American tribal document; or
10. Records from non-profit international aid agencies and voluntary agencies.

- **Proof of Custody and/or Lawful Residence**

In order for the District to confirm your custody of and/or lawful residence with your child, please submit either:

  - A written affidavit indicating that you are the parent(s) with whom the child lawfully resides; or

  - A written affidavit indicating that you are the person(s) in a parental relation to the child, over whom you have total and permanent custody and control and describing how you obtained total and permanent custody and whether it is through a guardianship or otherwise.

  - A judicial custody order or guardianship papers may, but need not be, submitted.

The District will also accept other proof of custody and/or lawful residence such as documentation which indicates that the child has been placed by a federal agency with a sponsor.

- **Current Immunization Record (official record signed by physician)**

The student's recent report card, standardize test results, I.E.P., or any other information from the previous school would be helpful.

Enrollment and Registration Process:

Upon request, your child will be enrolled and permitted to attend school in the District the next school day, or as soon as practicable.

Within three (3) business days of the child's initial enrollment, the Board of Education ("Board"), or its designee, will review all of the registration/enrollment documentation submitted and determine whether the child is entitled to attend school in the District. If it is determined that the child does not reside in the District, the Board, within two (2) business days, will issue a written notification confirming the basis for this determination and the date the child is to be excluded from the District. The written notification will also confirm the parent's right to appeal the Board's decision to the New York Commissioner of Education within thirty (30) days and advise that the instructions, forms and procedures for an appeal, including translated instruction forms and procedures can be found at the following:

- Online at the Office of Counsel, www.counsel.nysed.gov;
- Mail addressed to the Office of Counsel, New York State Education Department, State Education Building in Albany, New York 12234; or
- Calling the Appeals Coordinator at (518) 474-8927.

Thank you in advance for your cooperation with the District's registration and enrollment process. I look forward to meeting you and if you have any questions, please feel free to call me at 439-2442.

Sincerely,

Melissa Haas,
Central Registrar

Bethlehem CENTRAL SCHOOL DISTRICT

Welcome to Bethlehem Schools!

STAY CONNECTED TO BETHLEHEM IN MANY WAYS

For a large portion of the day, you leave your children in our care. The education of the students in our community is a responsibility we don't take lightly, and something we know doesn't stop when students leave school. Working together has always been a huge part of our process, so please stay connected!

District Website

www.bethlehemschools.org

Have you been to Bethlehem Central's website lately?

Visit *www.bethlehemschools.org* to access all kinds of information about district activities, programs and announcements.

BC on Social Media

Follow us on Twitter!
@BethlehemCSD
Get up-to-date district news, live-tweets of important district meetings, and answers to your questions.

Become a fan on Facebook!
www.facebook.com/BethlehemSchools
View photos of what's happening in our schools and receive updates on events and school activities.

Follow us on Instagram!
@bethlehemschools
View photos and stories from our classrooms, athletics, the arts and from events across the district.

Aspen

www.bethlehemschools.org/aspen

Aspen is a password protected portal that offers parents and students online access to a secure site with personalized information about a student's academic program and progress. Your contact information you share at registration is uploaded automatically to Aspen by our District Registrar.

Student report cards and bus schedules are posted to Aspen, as well as iReady progress reports K-8 and academic schedules for students in grades 6-12. Some teachers also use Aspen to post assignments and to communicate with individual students/families. Always be sure to keep your contact information up to date. When you have changes to your address, phone or email, please contact the District Registrar to make sure those changes are reflected in Aspen.

Introducing ParentSquare

In the 2023-24 school year, the district will begin using ParentSquare for most school-to-home communications. BCSD will be consolidating the many communications tools used by the district, schools and by teachers so parents and guardians will have a one-stop communications tool with ParentSquare.

As a parent or guardian, you are automatically registered for ParentSquare through your contact information that is stored in Aspen. As long as the district has your correct contact information on file, you will receive timely, important updates from the district and your child's school. ParentSquare also allows you to customize the delivery of routine news and announcements by creating your own ParentSquare account. The ParentSquare mobile app provides even greater customization with push notifications that can be sent to your phone or mobile device. You can log into ParentSquare using the QR code below. If you need assistance, please contact bcsdcommunications@bethlehemschools.org.

SCAN

ParentSquare

ACCURATE CONTACT INFO IS IMPORTANT

If you need to update to your contact information, contact our District Registrar.

Melissa Haas
mhaas@bethlehemschools.org

Email us

All faculty and staff in the Bethlehem Central School District can be reached by email. Most email addresses are the first initial of the first name and the full last name and the domain name bethlehemschools.org. Ex. Ann Roberts is *aroberts@bethlehemschools.org*. A searchable email directory is available on the district website.

Follow your BC Eagles

Be where the action is! The BCSD Athletics Departments posts all sports information regularly on Twitter *@BCSDAthletics*

PARENT-TEACHER COMMUNICATIONS

The following information was adapted from Parent Today.

The key to productive parent-teacher conversations is keeping in mind that you are on the same team, working together to ensure your child's success. When you tell the teacher about your child's skills, interests and personality, the teacher has better insight into your child as an individual. And when the teacher shares insights about your child, you can promote a more positive learning environment at home.

Emails and phone calls

When you need to discuss a serious issue with a teacher or other staff member, keep in mind that it's sometimes difficult to interpret tone in written words. Talking directly to the teacher can, at times, be more effective than an email. Whether it's an email or a phone call, your child's teacher will do their best to respond as soon as possible. Please allow them 24 hours to respond.

Parent-Teacher Conferences

Parent-teacher conferences for elementary students are held in late fall. In order to maximize this time, the following tips from the Harvard Research Family Project can help you arrive prepared. These tips are also helpful for all types of parent-teacher interaction, in all grades K-12.

To get off to a solid start when meeting with your child's teacher, be prompt, stay positive and focus on the following:

PROGRESS

Find out how your child is doing by asking questions like: Is my child performing at grade level? How are they doing compared to the rest of the class? What do you see as their greatest strengths? In what areas could they improve? What can I do at home to help my child succeed in the classroom?

ASSIGNMENTS AND ASSESSMENTS

If your teacher has not already done so, ask to see examples of your child's work. Ask how the teacher assigns grades and homework.

SUPPORT LEARNING AT SCHOOL

Be sure to share your thoughts and feelings about your child's learning style, needs or concerns. Tell the teacher what you think your child is good at. Explain what your child may need more help with.

Find out what services are available at the school to help your child. Ask how the teacher will both challenge your child and support your child when they need it.

SUPPORT LEARNING AT HOME

Ask what you can do at home to help your child learn. Ask if the teacher knows of other programs or services in the community that could also help your child. Explore clubs, recreational and other activities that take place after school or in the community to ensure your child is engaged with their learning peers even after the school day ends.

BETHLEHEM CENTRAL SCHOOL DISTRICT

EAGLE ELEMENTARY SCHOOL
Dianna Reagan, Principal
27 Van Dyke Rd.
Delmar, NY 12054
518-694-8825

ELSMERE ELEMENTARY SCHOOL
Kate Kloss, Principal
247 Delaware Ave.
Delmar, NY 12054
518-439-4996

GLENMONT ELEMENTARY SCHOOL
Laura Heffernan, Principal
328 Rte. 9W
Glenmont, NY 12077
518-463-1154

HAMAGRAEL ELEMENTARY SCHOOL
Ian Knox, Principal
1 McGuffey Lane
Delmar, NY 12054
518-439-4905

SLINGERLANDS ELEMENTARY SCHOOL
Andrew Baker, Principal
25 Union Ave.
Delmar, NY 12054
518-439-7681

BETHLEHEM CENTRAL MIDDLE SCHOOL
Michael Klugman, Principal
332 Kenwood Ave.
Delmar, NY 12054
518-439-7460

BETHLEHEM CENTRAL HIGH SCHOOL
David Doemel, Jr., Principal
700 Delaware Ave.
Delmar, NY 12054
518-439-4921

Student Residency Questionnaire

Note: The Bethlehem Central School District uses this page to help identify students in homeless situations as required by the McKinney-Vento Homeless Assistance Improvements Act, 42 U.S.C.11435. Answers to this residency information help determine the services the student may be eligible to receive. Assistance is provided by our Homeless Liaison, Mr. David F. Hurst. He can be reached at (518) 439-3102 or in the Educational Service Center at 700 Delaware Avenue.

Name of School: _____

Name of Student: _____ Gender:
Last *First* *Middle*

Birth Date: _____/_____/_____ Grade: _____ Student ID #: _____
Month *Day* *Year* *(optional)*

Address: _____ Phone: _____

The answer you give below will help the district determine what services you or your child may be able to receive under the McKinney-Vento Act. Students who are protected under the McKinney-Vento Act are entitled to immediate enrollment in school even if they don't have the documents normally needed, such as proof of residency, school records, immunization records, or birth certificate. Students who are protected under the McKinney-Vento Act may also be entitled to free transportation and other services.

Where is the student currently living? (*Check one box.*)

- ❑ In a motel/hotel
- ❑ In a shelter
- ❑ With another family or other person because of loss of housing or as a result of economic hardship (sometimes referred to as "doubled-up")
- ❑ In a car, park, bus, train, or campsite
- ❑ Other temporary living situation (Please describe): _____
- ❑ In permanent housing

_____ _____
Print Name of Parent, Guardian, or Student (for unaccompanied homeless youth)

Signature of Parent, Guardian, or Student (for unaccompanied homeless youth)

_____
Date

If the student is **NOT** living in permanent housing, **proof of residency** and other documents normally needed for enrollment **are not required** and the **student is to be immediately enrolled.** The district's LEA liaison is required to assist the student obtaining any necessary documents, including immunization or school records after the student has been enrolled.

Bethlehem Central School District
Office of the Registrar
700 Delaware Avenue
Delmar, NY 12054
(518) 439-2442
www.bethlehemschools.org

For Office Use Only

Enroll Date _____ Proofs of Residence _____

Immunizations: Y or N Birth Certificate: Y or N Other_____

Student ID# _____ Family **#** _____

Home School: EAG EL GL HAM SL MS HS

STUDENT ENROLLMENT FORM

The information on this form is very important. ***PLEASE PRINT CLEARLY.***

Student Name_____Gender: ❒F ❒M ❒X Grade: _____

(First name, Middle initial, Last name as it appears on birth certificate)

Preferred Name_____ *Preferred name will be used on all unoffical district documents. Offical documents (transcripts, etc.) will use the legal name above.*

Date of Birth_____ Home Phone_____

Home Address_____
(Number) (Street) (Town) (Zip Code)

Mailing Address (if different and/or P.O. box) _____

Previous School District Attended: _____

Has your child ever attended a Bethlehem school? YES ☐ or NO ☐ If Yes, When?_____ Last Grade _____

Name(s) of siblings residing with student: (Attach additional sheet if needed.)

Name *(First, Middle initial, Last)*	F/ M / X	Birth date (m/d/yy)	Grade	School

Are there any restricted releases for this child? [Documentation required. Please attach.] _____

Parent 1 Name: Dr. / Mr. / Mrs. / Ms._____
(First name, Middle initial, Last name)

Relationship to student _____

Address (if different from student) _____

❒ Lives with Student ❒ Has Custody of Student ❒ Should Receive Student Mailings/Aspen

Home Phone _____ Work Phone _____ Cell Phone _____

Primary Email Address: _____

Employer's Name:_____ Position: _____

Parent 2 Name: Dr. / Mr. / Mrs. / Ms. _____
(First name, Middle initial, Last name)

Relationship to student _____

Address (if different from student) _____

❒ Lives with Student ❒ Has Custody of Student ❒ Should Receive Student Mailings/Aspen

Home Phone _____ Work Phone _____ Cell Phone _____

Primary Email Address: _____

Employer's Name: _____ Position: _____

*If parent/guardian **cannot be reached please contact:***

Emergency Contact 1 Name: Dr. / Mr. / Mrs. / Ms. _____
(First name, Middle initial, Last name)

Relationship to student _____

Address _____

❒ Lives with Student ❒ Has Custody of Student ❒ Should Receive Student Mailings/Aspen

Home Phone _____ Work Phone _____ Cell Phone _____

Primary Email: _____

Employer's Name: _____ Position: _____

Emergency Contact 2 Name: Dr. / Mr. / Mrs. / Ms. _____
(First name, Middle initial, Last name)

Relationship to student _____

Address _____

❒ Lives with Student ❒ Has Custody of Student ❒ Should Receive Student Mailings/Aspen

Home Phone _____ Work Phone _____ Cell Phone _____

Primary Email: _____

Employer's Name _____ Position: _____

If your child has received special education services or accommodation through an Individualized Education Program (IEP) or a Section 504, please sign a consent for the release of special education records so that special education services can begin as soon as possible.

Consent for release of special education records signed?

❒ YES ❒ NO

Parent Statement:

I certify the above information is true and correct. Any misinformation regarding residency may result in being billed to cover the cost of instruction and/or exclusion from attending the Bethlehem Central School District.

_____ _____
Parent Signature *Date*

Bethlehem Central Schools
Kindergarten Registration

FORM B/Buff

KINDERGARTEN QUESTIONNAIRE

This questionnaire will help the kindergarten teachers get acquainted with your child and will assist the teacher in planning a program appropriate to your child and his/her classmates. All responses will be kept confidential, and the questionnaire will not become a part of your child's records.

1. Name of child_____ 2. Gender: ❑ M ❑ F ❑ X

3. Name child prefers/Nickname _____ 4. Birthdate_____

5. Home telephone number _____

6. Child lives with: (check one)

Mother and Father: ❑ Mother only: ❑ Mother and Mother: ❑

Mother and Stepfather: ❑ Father only: ❑ Father and Father: ❑

Father and Stepmother: ❑ Guardian: ❑ Other: _____

7. Are there any health considerations/health history we should be aware of?

_____

8. Are there any special situations, in your family that might affect the behavior or learning needs of your child (e.g., unemployment, illness, death)? No ❑ Yes ❑ Explain _____

9. Has your child had these educational experiences? (check those that apply)

❑ nursery school (Name _____ ½ day ❑ full day ❑)

❑ day care center (Name _____ ½ day ❑ full day ❑)

10. Is your child's speech sometimes difficult to understand?

No ❑ Yes ❑

11. Please check items that your child has had experience with in the home:

❑ books ❑ paints ❑ puzzles ❑ paste

❑ pencils ❑ scissors ❑ crayons ❑ computers

12. Is a language other than English spoken in the home? No ❑ Yes ❑

If so, what language? _____

13. Please share with us any other information that you feel might help us to better understand your child this year. (Any special talents, needs, preschool experiences, fears and /or anxieties, and favorite activities.)

_____

_____

_____

_____

14. Please share goals you have for your child for this year (social, emotional, language, and cognitive).

_____

_____

_____

_____

Bethlehem Central School District
Office of the Registrar
700 Delaware Avenue
Delmar, NY 12054
(518) 439-2442

HEALTH HISTORY FOR NEW ENTRANTS

This form should be completed and signed by the parent or guardian

Home School *(Please circle one)* **EAG** **ELS** **GLE** **HAM** **SLI**

Name _____ DOB _____

Family Physician _____ Phone _____

Last visit to M.D.*(date, reason)* _____ Date of last physical _____ Next M.D. visit *(date, reason)*_____

Dentist _____ Phone _____

Pregnancy History (gestational diabetes, bed rest, medication needs)

_____

Labor and Birth History (emergency delivery, premature labor, birth trauma, delayed discharge from hospital): _____

_____

Gestation: _____ Full term _____ Premature Delivery: _____Vaginal _____ Cesarean Birth Weight: _____

Growth and Development / Walked at age: _____ Spoke first word at age: _____ Spoke sentences at age: _____

Health History

Serious illness: _____

Serious injury: _____

Surgery: _____

Check if your child has, or has had, any of the following and provide date when appropriate:

_____ Allergies
_____ Animals
_____ Bee sting
_____ Food
_____ Medication
_____ Seasonal
_____ Other
_____ Anemia
_____ Asthma
_____ Cerebral Palsy
_____ Chicken Pox *(documentation)*
_____ Colds & Sore Throats
_____ Concussion, ***date***:
_____ Convulsions
_____ With fever
_____ Without fever
_____ Cystic Fibrosis
_____ Diabetes
_____ Ear Infections
_____ History of PE Tubes
_____ Eye Conditions
_____ Hearing Problem
_____ Heart Disease
_____ Hypotonia
_____ Kidney Disease
_____ Learning Disabilities
_____ Leukemia
_____ Lyme Disease, ***date***:
_____ Measles
_____ Mononucleosis
_____ Mumps
_____ Orthopedic Conditions
_____ Pneumonia
_____ Rheumatic Disease
_____ Rubella Disease
_____ Scarlet Fever
_____ Seizure Disorder
_____ Speech Problem
_____ Strep Throat
_____ TB, ***date:***
_____Chest X-ray, ***date***:
_____ Urinary Infections
_____ Urinary Reflux
_____ Vision Problem
Last Vision Exam:
Vision Specialist:
Glasses Worn: YES NO
_____ Whooping Cough

Current Health Status (Please state if your child is, or has been, under treatment, or taking medication):

Health conditions under treatment: _____

Medical provider(s) providing treatment: _____

Medication(s) Please list all over the counter and prescription medications, including dose and frequency: _____

_____

_____

Will medications need to be given while your child is at school?

_____ Yes _____ Not known at this time

Are the any physical restrictions or limitations for physical education or other activities at school?

_____ Yes _____ No *** If restrictions or limitations, M.D. documentation is required**

Has your child ever received, or is currently receiving, the following services:

_____ OT _____ PT _____ Speech _____ Other

_____ _____

Parent/Guardian Signature *Date*

2023-24 School Year
New York State Immunization Requirements for School Entrance/Attendance[1]

NOTES:
All children must be age-appropriately immunized to attend school in NYS. The number of doses depends on the schedule recommended by the Advisory Committee on Immunization Practices (ACIP). Intervals between doses of vaccine must be in accordance with the "ACIP-Recommended Child and Adolescent Immunization Schedule." Doses received before the minimum age or intervals are not valid and do not count toward the number of doses listed below. See footnotes for specific information for each vaccine. Children who are enrolling in grade-less classes must meet the immunization requirements of the grades for which they are age equivalent.

Dose requirements MUST be read with the footnotes of this schedule

Vaccines	Pre-Kindergarten (Day Care, Head Start, Nursery or Pre-K)	Kindergarten and Grades 1, 2, 3, 4 and 5	Grades 6, 7, 8, 9, 10 and 11	Grade 12
Diphtheria and Tetanus toxoid-containing vaccine and Pertussis vaccine (DTaP/DTP/Tdap/Td)[2]	**4 doses**	**5 doses** **or 4 doses** if the 4th dose was received at 4 years or older or **3 doses** if 7 years or older and the series was started at 1 year or older	**3 doses**	
Tetanus and Diphtheria toxoid-containing vaccine and Pertussis vaccine adolescent booster (Tdap)[3]	**Not applicable**		**1 dose**	
Polio vaccine (IPV/OPV)[4]	**3 doses**	**4 doses** **or 3 doses** if the 3rd dose was received at 4 years or older		
Measles, Mumps and Rubella vaccine (MMR)[5]	**1 dose**	**2 doses**		
Hepatitis B vaccine[6]	**3 doses**	**3 doses** **or 2 doses** of **adult hepatitis B vaccine** (Recombivax) for children who received the doses at least 4 months apart between the ages of 11 through 15 years		
Varicella (Chickenpox) vaccine[7]	**1 dose**	**2 doses**		
Meningococcal conjugate vaccine (MenACWY)[8]	**Not applicable**		**Grades 7, 8, 9, 10 and 11: 1 dose**	**2 doses** **or 1 dose** if the dose was received at 16 years or older
Haemophilus influenzae type b conjugate vaccine (Hib)[9]	**1 to 4 doses**	**Not applicable**		
Pneumococcal Conjugate vaccine (PCV)[10]	**1 to 4 doses**	**Not applicable**		

NEW YORK STATE | Department of Health

1. Demonstrated serologic evidence of measles, mumps or rubella antibodies or laboratory confirmation of these diseases is acceptable proof of immunity to these diseases. Serologic tests for polio are acceptable proof of immunity only if the test was performed before September 1, 2019, and all three serotypes were positive. A positive blood test for hepatitis B surface antibody is acceptable proof of immunity to hepatitis B. Demonstrated serologic evidence of varicella antibodies, laboratory confirmation of varicella disease or diagnosis by a physician, physician assistant or nurse practitioner that a child has had varicella disease is acceptable proof of immunity to varicella.

2. Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine. (Minimum age: 6 weeks)
   a. Children starting the series on time should receive a 5-dose series of DTaP vaccine at 2 months, 4 months, 6 months and at 15 through 18 months and at 4 years or older. The fourth dose may be received as early as age 12 months, provided at least 6 months have elapsed since the third dose. However, the fourth dose of DTaP need not be repeated if it was administered at least 4 months after the third dose of DTaP. The final dose in the series must be received on or after the fourth birthday and at least 6 months after the previous dose.
   b. If the fourth dose of DTaP was administered at 4 years or older, and at least 6 months after dose 3, the fifth (booster) dose of DTaP vaccine is not required.
   c. Children 7 years and older who are not fully immunized with the childhood DTaP vaccine series should receive Tdap vaccine as the first dose in the catch-up series; if additional doses are needed, use Td or Tdap vaccine. If the first dose was received before their first birthday, then 4 doses are required, as long as the final dose was received at 4 years or older. If the first dose was received on or after the first birthday, then 3 doses are required, as long as the final dose was received at 4 years or older.

3. Tetanus and diphtheria toxoids and acellular pertussis (Tdap) adolescent booster vaccine. (Minimum age for grades 6 through 9: 10 years; minimum age for grades 10, 11, and 12: 7 years)
   a. Students 11 years or older entering grades 6 through 12 are required to have one dose of Tdap.
   b. In addition to the grade 6 through 12 requirement, Tdap may also be given as part of the catch-up series for students 7 years of age and older who are not fully immunized with the childhood DTaP series, as described above. In school year 2023-2024, only doses of Tdap given at age 10 years or older will satisfy the Tdap requirement for students in grades 6 through 9; however, doses of Tdap given at age 7 years or older will satisfy the requirement for students in grades 10, 11, and 12.
   c. Students who are 10 years old in grade 6 and who have not yet received a Tdap vaccine are in compliance until they turn 11 years old.

4. Inactivated polio vaccine (IPV) or oral polio vaccine (OPV). (Minimum age: 6 weeks)
   a. Children starting the series on time should receive a series of IPV at 2 months, 4 months and at 6 through 18 months, and at 4 years or older. The final dose in the series must be received on or after the fourth birthday and at least 6 months after the previous dose.
   b. For students who received their fourth dose before age 4 and prior to August 7, 2010, 4 doses separated by at least 4 weeks is sufficient.
   c. If the third dose of polio vaccine was received at 4 years or older and at least 6 months after the previous dose, the fourth dose of polio vaccine is not required.
   d. For children with a record of OPV, only trivalent OPV (tOPV) counts toward NYS school polio vaccine requirements. Doses of OPV given before April 1, 2016, should be counted unless specifically noted as monovalent, bivalent or as given during a poliovirus immunization campaign. Doses of OPV given on or after April 1, 2016, must not be counted.

5. Measles, mumps, and rubella (MMR) vaccine. (Minimum age: 12 months)
   a. The first dose of MMR vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (4 weeks) after the first dose to be considered valid.
   b. Measles: One dose is required for prekindergarten. Two doses are required for grades kindergarten through 12.
   c. Mumps: One dose is required for prekindergarten. Two doses are required for grades kindergarten through 12.
   d. Rubella: At least one dose is required for all grades (prekindergarten through 12).

6. Hepatitis B vaccine
   a. Dose 1 may be given at birth or anytime thereafter. Dose 2 must be given at least 4 weeks (28 days) after dose 1. Dose 3 must be at least 8 weeks after dose 2 AND at least 16 weeks after dose 1 AND no earlier than age 24 weeks (when 4 doses are given, substitute “dose 4” for “dose 3” in these calculations).
   b. Two doses of adult hepatitis B vaccine (Recombivax) received at least 4 months apart at age 11 through 15 years will meet the requirement.

7. Varicella (chickenpox) vaccine. (Minimum age: 12 months)
   a. The first dose of varicella vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (4 weeks) after the first dose to be considered valid.
   b. For children younger than 13 years, the recommended minimum interval between doses is 3 months (if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid); for persons 13 years and older, the minimum interval between doses is 4 weeks.

8. Meningococcal conjugate ACWY vaccine (MenACWY). (Minimum age for grades 7 through 10: 10 years; minimum age for grades 11 and 12: 6 weeks).
   a. One dose of meningococcal conjugate vaccine (Menactra, Menveo or MenQuadfi) is required for students entering grades 7, 8, 9, 10 and 11.
   b. For students in grade 12, if the first dose of meningococcal conjugate vaccine was received at 16 years or older, the second (booster) dose is not required.
   c. The second dose must have been received at 16 years or older. The minimum interval between doses is 8 weeks.

9. Haemophilus influenzae type b (Hib) conjugate vaccine. (Minimum age: 6 weeks)
   a. Children starting the series on time should receive Hib vaccine at 2 months, 4 months, 6 months and at 12 through 15 months. Children older than 15 months must get caught up according to the ACIP catch-up schedule. The final dose must be received on or after 12 months.
   b. If 2 doses of vaccine were received before age 12 months, only 3 doses are required with dose 3 at 12 through 15 months and at least 8 weeks after dose 2.
   c. If dose 1 was received at age 12 through 14 months, only 2 doses are required with dose 2 at least 8 weeks after dose 1.
   d. If dose 1 was received at 15 months or older, only 1 dose is required.
   e. Hib vaccine is not required for children 5 years or older.
   f. For further information, refer to the CDC Catch-Up Guidance for Healthy Children 4 Months through 4 Years of Age.

10. Pneumococcal conjugate vaccine (PCV). (Minimum age: 6 weeks)
    a. Children starting the series on time should receive PCV vaccine at 2 months, 4 months, 6 months and at 12 through 15 months. Children older than 15 months must get caught up according to the ACIP catch-up schedule. The final dose must be received on or after 12 months.
    b. Unvaccinated children ages 7 through 11 months are required to receive 2 doses, at least 4 weeks apart, followed by a third dose at 12 through 15 months.
    c. Unvaccinated children ages 12 through 23 months are required to receive 2 doses of vaccine at least 8 weeks apart.
    d. If one dose of vaccine was received at 24 months or older, no further doses are required.
    e. PCV is not required for children 5 years or older.
    f. For further information, refer to the CDC Catch-Up Guidance for Healthy Children 4 Months through 4 Years of Age.

For further information, contact:

New York State Department of Health
Bureau of Immunization
Room 649, Corning Tower ESP
Albany, NY 12237
(518) 473-4437

New York City Department of Health and Mental Hygiene
Program Support Unit, Bureau of Immunization,
42-09 28th Street, 5th floor
Long Island City, NY 11101
(347) 396-2433

Bethlehem Central School District
http://bethlehemschools.org

IMMUNIZATION REQUIREMENTS FOR SCHOOL ENTRANCE/ATTENDANCE

Acceptable Proofs of Immunizations

Health care practitioner record, signed by practitioner licensed in New York State. ***Records acceptable without a signature*:** NYSIIS Record; Official registry from another State; Electronic health record; School health record, (*must be transferred **directly** from one school to another*); Official record from a foreign nation

Diagnosis of Disease as Evidence of Immunity

ONLY allowed for varicella. Must be diagnosed by a physician, nurse practitioner, or physician's assistant.

Serological Evidence of Immunity

Allowed for measles, mumps, rubella, varicella, hepatitis B and poliomyelitis (*all three serotypes must be positive. Testing for all three polio serotypes is no longer available in the United States.*)

Medical Exemptions

A student may attend school without the required immunizations if they have a medical exemption. Bethlehem Central School District requests that the following NYSDOH form https://www.health.ny.gov/forms/doh-5077.pdf be completed by a physician licensed to practice medicine in NYS certifying that the immunization may be detrimental to the child's health. It must contain sufficient information to identify a medical contraindication to a specific immunization, and specify the length of time the immunization is medically contraindicated. Once the completed form is received it will be reviewed by the District's Medical Director to determine if additional documentation is required. **A medical exemption must be reissued *annually*.**

References

New York State Department of Health, ***Immunization Laws***
https://www.health.ny.gov/prevention/immunization/laws_regs.htm

New York State ***Immunization Requirements for School Entrance / Attendance***
https://www.health.ny.gov/publications/2370.pdf

New York State Department of Health, ***Childhood and Adolescent Immunizations***
https://www.health.ny.gov/prevention/immunization/childhood_and_adolescent.htm

Albany County Department of Health, ***Immunization Program***
https://www.albanycounty.com/departments/health/programs-services/immunization-program#:~:text=Vaccines%20are%20provided%20against%20childhood,(518)%20447%2D4589.

Bethlehem Central School District

http://bethlehemschools.org

ACADEMICS
CHARACTER
COMMUNITY
WELLNESS

Dear Parent or Guardian:

As part of your child's requirement for school, a physical examination is required for students in kindergarten, grades 1, 3, 5, 7, 9, 11 and all new entrants. A NYS School Health Examination Form is attached, to be filled out by your private physician.

Per a recently enacted law, the grades your child has a physical examination we also **request** a dental certificate. A sample certificate is attached. It should be returned to the school nurse and will be filed with your child's cumulative health record when completed.

Thank you for your cooperation in these health endeavors to promote wellness and academic success. Please feel free to contact the Health Office at your child's school if you have any questions or concerns.

Bethlehem Central High School
(518) 439-4921

Bethlehem Central Middle School
(518) 439-7705

Eagle Elementary School
(518) 694-3953

Elsmere Elementary School
(518) 439-3019

Glenmont Elementary School
(518) 434-1246

Hamagrael Elementary School
(518) 439-8889

Slingerlands Elementary School
(518) 439-8984

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM
TO BE COMPLETED BY PRIVATE HEALTHCARE PROVIDER OR SCHOOL MEDICAL DIRECTOR
IF AN AREA IS NOT ASSESSED INDICATE NOT DONE

Note: NYSED requires a physical exam for new entrants and students in Grades Pre-K or K, 1, 3, 5, 7, 9 & 11; annually for interscholastic sports; and working papers as needed; or as required by the Committee on Special Education (CSE) or Committee on Pre-School Special education (CPSE).

STUDENT INFORMATION

Name:	Affirmed Name (if applicable):	DOB:
Sex Assigned at Birth: ☐ Female ☐ Male	Gender Identity: ☐ Female ☐ Male ☐ Nonbinary ☐ X	
School:	Grade:	Exam Date:

HEALTH HISTORY

If yes to any diagnoses below, check all that apply and provide additional information.

☐ **Allergies**	Type: ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
☐ **Asthma**	☐ Intermittent ☐ Persistent ☐ Other: ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
☐ **Seizures**	Type: Date of last seizure: ☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
☐ **Diabetes**	Type: ☐ 1 ☐ 2 ☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached

Risk Factors for Diabetes or Pre-Diabetes: *Consider screening for T2DM if BMI% > 85% and has 2 or more risk factors:Family Hx T2DM, Ethnicity, Sx Insulin Resistance, Gestational Hx of Mother, and/or pre-diabetes.*

BMI_____kg/m2

Percentile (Weight Status Category): ☐ < 5th ☐ 5th- 49th ☐ 50th- 84th ☐ 85th- 94th ☐ 95th- 98th ☐ 99th and >

Hyperlipidemia: ☐ Yes ☐ Not Done **Hypertension:** ☐ Yes ☐ Not Done

PHYSICAL EXAMINATION/ASSESSMENT

Height: **Weight:** **BP:** **Pulse:** **Respirations:**

Laboratory Testing	Positive	Negative	Date	Lead Level Required for PreK & K	Date
TB- PRN	☐	☐		☐ Test Done ☐ Lead Elevated ≥5 µg/dL	
Sickle Cell Screen-PRN	☐	☐			

☐ **System Review Within Normal Limits**

☐ **Abnormal Findings – List Other Pertinent Medical Concerns Below** (e.g., concussion, mental health, one functioning organ)

☐ HEENT	☐ Lymph nodes	☐ Abdomen	☐ Extremities	☐ Speech
☐ Dental	☐ Cardiovascular	☐ Back/Spine/Neck	☐ Skin	☐ Social Emotional
☐ Mental Health	☐ Lungs	☐ Genitourinary	☐ Neurological	☐ Musculoskeletal

☐ Assessment/Abnormalities Noted/Recommendations:	Diagnoses/Problems (list) ICD-10 Code*
☐ Additional Information Attached	*Required only for students with an IEP receiving Medicaid

Name:	Affirmed Name (if applicable):	DOB:

SCREENINGS

Vision & Hearing Screenings Required for PreK or K, 1, 3, 5, 7, & 11

Vision	**With Correction** ☐ Yes ☐ No	**Right**	**Left**	**Referral**	**Not Done**
Distance Acuity		20/	20/	☐ Yes	☐
Near Vision Acuity		20/	20/		☐
Color Perception Screening	☐ Pass ☐ Fail				☐

Notes

Hearing Passing indicates student can hear 20dB at all frequencies: 500, 1000, 2000, 3000, 4000 Hz; for grades 7 & 11 also test at 6000 & 8000 Hz.				**Not Done**
Pure Tone Screening	**Right** ☐ Pass ☐ Fail	**Left** ☐ Pass ☐ Fail	**Referral** ☐ Yes	☐

Notes

Scoliosis Screening: Boys grade 9, Girls grades 5 & 7	**Negative**	**Positive**	**Referral**	**Not Done**
	☐	☐	☐ Yes	☐

FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS*/PLAYGROUND/WORK

☐ ***Family cardiac history reviewed –** required for Dominick Murray Sudden Cardiac Arrest Prevention Act

☐ **Student may participate in all activities without restrictions.**

If Restrictions Apply – Complete the information below

☐ **Student is restricted from participation in:**

- ☐ **Contact Sports:** Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.
- ☐ **Limited Contact Sports:** Baseball, Fencing, Softball, and Volleyball.
- ☐ **Non-Contact Sports:** Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.
- ☐ **Other Restrictions:**

Developmental Stage for Athletic Placement Process ONLY required for students in Grades 7 & 8 who wish to play at the high school interscholastic sports level **OR** Grades 9-12 who wish to play at the modified interscholastic sports level.

Tanner Stage: ☐ I ☐ II ☐ III ☐ IV ☐ V

☐ **Other Accommodations*:** (e.g., brace, orthotics, insulin pump, prosthetic, sports goggles, etc.) Use additional space below to explain.

*Check with the athletic governing body if prior approval/form completion is required for use of the device at athletic competitions.

MEDICATIONS

☐ Order Form for medication(s) needed at school attached

COMMUNICABLE DISEASE	**IMMUNIZATIONS**
☐ Confirmed free of communicable disease during exam	☐ Record Attached ☐ Reported in NYSIIS

HEALTHCARE PROVIDER

Healthcare Provider Signature:	
Provider Name: *(please print)*	
Provider Address:	
Phone:	Fax:

Please Return This Form to Your Child's School Health Office When Completed.

Bethlehem Central School District

Dental Health Certificate

Parent/Guardian: New York State law (Chapter 281) permits schools to request an oral health assessment in the following grades: K, 1, 3, 5, 7, 9, 11, and all new entrants. Your child may have a dental check-up during this school year to assess his/her fitness to attend school. Please complete Section 1 and take the form to your registered dentist or registered dental hygienist for an assessment. If your child had a dental check-up before he/she started the school, ask your dentist/dental hygienist to fill out Section 2. Return the completed form to the school's medical director or school nurse as soon as possible.

Section 1. To be completed by Parent or Guardian (Please Print)

Child's Name: Last First Middle

Birth Date: Month Day Year

Sex: ☐ Male ☐ Female

Will this be your child's first oral health assessment ? ☐ Yes ☐ No

School: Name

Grade

Have you noticed any problem in the mouth that interferes with your child's ability to chew, speak or focus on school activities? ☐ Yes ☐ No

I understand that by signing this form I am consenting for the child named above to receive a basic oral health assessment. I understand this assessment is only a limited means of evaluation to assess the student's dental health, and I would need to secure the services of a dentist in order for my child to receive a complete dental examination with x-rays if necessary to maintain good oral health.

I also understand that receiving this preliminary oral health assessment does not establish any new, ongoing or continuing doctor-patient relationship. Further, I will not hold the dentist or those performing this assessment responsible for the consequences or results should I choose NOT to follow the recommendations listed below.

Parent's Signature Date

Section 2. To be completed by the Dentist/ Dental Hygienist

I. The dental health condition of_____ on_____(date of assessment) The date of the assessment needs to be within 12 months of the start of the school year in which it is requested. Check one:

☐ Yes, The student listed above is in fit condition of dental health to permit his/her attendance at the public schools.

☐ No, The student listed above is not in fit condition of dental health to permit his/her attendance at the public schools.

NOTE: Not in fit condition of dental health means that a condition exists that interferes with a student's ability to chew, speak or focus on school activities including pain, swelling or infection related to clinical evidence of open cavities. The designation of not in fit condition of dental health to permit attendance at the public school does not preclude the student from attending school.

Dentist's/ Dental Hygienist's name and address

(please print or stamp)

Dentist's/Dental Hygienist's Signature

Optional Sections - If you agree to release this information to your child's school, please initial here. ☐

II. Oral Health Status (check all that apply).

☐ Yes ☐ No **Caries Experience/Restoration History –** Has the child ever had a cavity (treated or untreated)? [A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR an open cavity].

☐ Yes ☐ No **Untreated Caries –** Does this child have an open cavity? [At least ½ mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pits and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present].

☐ Yes ☐ No **Dental Sealants Present**

Other problems (Specify):_____

II. Treatment Needs (check all that apply)

☐ No obvious problem. Routine dental care is recommended. Visit your dentist regularly.

☐ May need dental care. Please schedule an appointment with your dentist as soon as possible for an evaluation.

☐ Immediate dental care is required. Please schedule an appointment immediately with your dentist to avoid problems.

Bethlehem Central School District
Office of the Registrar
700 Delaware Avenue
Delmar, NY 12054
(518) 439-2442

EAR HEALTH HISTORY

Child's Name_____ Date of Birth _____ Date _____

Parent/Guardian _____ Child's Age _____

Please help us better understand your child by answering the following questions:

1. Does your child have normal hearing (when ears are clean and healthy)? _____

_____

2. Did your child ever have ear infections? If so, how many total? _____

Between birth to 1 year old _____ 3 to 4 years old _____

1 to 2 years old_____ 4 to 5 years old _____

2 to 3 years old _____ 5+ years old_____

How long did the ear infections last? _____

How often did they re-occur? _____

3. Has your child had myringotomies and PE tubes inserted? _____

If so, how many times and at what ages? _____

4. Has your child ever been seen by an ear, nose, and throat doctor? _____

5. Has your child ever been seen by an audiologist for hearing testing? _____

6. Has your child received speech/language therapy? _____

If so, at what ages and for how long? _____

Therapy was for: _____ articulation _____

language or other_____ (please explain) _____

7. Has your child received amplification during periods of not hearing? _____

_____

8. Is there anything else in your child's ear health history that may be helpful in understanding your child's educational needs?

_____

_____

9. What concerns do you have about your child and school? _____

_____

_____

from Davis, Dorinne. ***Otitis Media: Coping with the Effects in the Classroom***.
Hear You Are, Inc.: Stanhope, NJ, 1989.

STATE EDUCATION DEPARTMENT / THE UNIVERSITY OF THE STATE OF NEW YORK / ALBANY, NY 12234
Office of P-12

Lissette Colón-Collins, Assistant Commissioner
Office of Bilingual Education and World Languages

55 Hanson Place, Room 594
Brooklyn, New York 11217
Tel: (718) 722-2445 / Fax: (718) 722-2459

89 Washington Avenue, Room 528EB
Albany, New York 12234
(518) 474-8775 / Fax: (518) 474-7948

Home Language Questionnaire (HLQ)

Dear Parent or Guardian:
In order to provide your child with the best possible education, we need to determine how well he or she understands, speaks, reads and writes in English, as well as prior school and personal history. Please complete the sections below entitled Language Background and Educational History. Your assistance in answering these questions is greatly appreciated. Thank you.

Please write clearly when completing this section.

STUDENT NAME:

First *Middle* *Last*

DATE OF BIRTH:

Month *Day* *Year*

GENDER:

❑ Male
❑ Female

PARENT/PERSON IN PARENTAL RELATION INFO:

Last Name *First Name* *Relation to Student*

HOME LANGUAGE CODE

Language Background
(Please check all that apply.)

1. What language(s) is(are) spoken in the student's home or residence?	❑ English	❑ Other _____ *specify*	
2. What was the first language your child learned?	❑ English	❑ Other _____ *specify*	
3. What is the Home Language of each parent/guardian?	❑ Mother _____ *specify*	❑ Father _____ *specify*	❑ Guardian(s) _____ *specify*
4. What language(s) does your child understand?	❑ English	❑ Other _____ *specify*	
5. What language(s) does your child speak?	❑ English	❑ Other _____ *specify*	❑ Does not speak
6. What language(s) does your child read?	❑ English	❑ Other _____ *specify*	❑ Does not read
7. What language(s) does your child write?	❑ English	❑ Other _____ *specify*	❑ Does not write

THIS SECTION TO BE COMPLETED BY DISTRICT IN WHICH STUDENT IS REGISTERED:

SCHOOL DISTRICT INFORMATION:	**STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:**
District Name (Number) & School *Address*	

Home Language Questionnaire (HLQ)—Page Two

Educational History

8. Indicate the total number of years that your child has been enrolled in school _____

9. Do you think your child may have any difficulties or conditions that affect his or her ability to understand, speak, read or write in English or any other language? If yes, please describe them.

Yes ☐ ***No*** ☑ ***Not sure*** ☐ ***If yes,** please explain:_____

How severe do you think these difficulties are? ❑ Minor ❑ Somewhat severe ❑ Very severe

10a. Has your child ever been *referred* for a special education evaluation in the past? ❑ No ❑ Yes* **Please complete 10b below*

10b. **If referred for an evaluation,* has your child ever *received* any special education services in the past?
❑ No ❑ Yes – Type of services received:_____

Age at which services received *(Please check all that apply):*
❑ Birth to 3 years (Early Intervention) ❑ 3 to 5 years (Special Education) ❑ 6 years or older (Special Education)

10c. Does your child have an Individualized Education Program (IEP)? ❑ No ❑ Yes

11. Is there anything else you think is important for the school to know about your child? *(e.g., special talents, health concerns, etc.)*

12. In what language(s) would you like to receive information from the school? _____

_____ Month: Day: Year:

Signature of Parent or of Person in Parental Relation ***Date***

Relationship to student: ❑ Mother ❑ Father ❑ Other:_____

OFFICIAL ENTRY ONLY - NAME/POSITION OF PERSONNEL ADMINISTERING HLQ

NAME: _____ **POSITION:** _____

IF AN INTERPRETER IS PROVIDED, LIST NAME, POSITION AND CREDENTIALS:

NAME/POSITION OF QUALIFIED PERSONNEL REVIEWING HLQ AND CONDUCTING INDIVIDUAL INTERVIEW

NAME: _____ **POSITION:** _____

ORAL INTERVIEW NECESSARY: ❑ NO ❑ YES

****DATE OF INDIVIDUAL INTERVIEW:** _____ (MO DAY YR.)

OUTCOME OF INDIVIDUAL INTERVIEW:
❑ ADMINISTER NYSITELL
❑ ENGLISH PROFICIENT
❑ REFER TO LANGUAGE PROFICIENCY TEAM

NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL

NAME: _____ **POSITION:** _____

DATE OF NYSITELL ADMINISTRATION: _____ (MO. DAY YR.)

PROFICIENCY LEVEL ACHIEVED ON NYSITELL: ❑ ENTERING ❑ EMERGING ❑ TRANSITIONING ❑ EXPANDING ❑ COMMANDING

FOR STUDENTS WITH DISABILITIES, LIST ACCOMMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION:

Herkimer-Fulton-Hamilton-Otsego BOCES
Migrant Education Tutorial & Support Services
Mary Kline, Migrant Education Director

352 Gros Boulevard
Herkimer NY 13350
315-867-2079

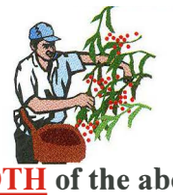
Eligibility Screen for Migrant Education Services

*** Migrant Education Program services are free of charge and may include tutoring, assistance with health needs, educational field trips, summer programs, parent involvement activities, adult education, emergency assistance and referrals to other services as needed. ***

Has your family moved to a different school district in the last 3 years? YES ☐ NO ☑

In the last three years, has the parent or guardian of the child enrolling done farm work as a paid job? (Did they work on a dairy farm, planting, picking/harvesting fruits or vegetables, food processing or packaging, logging or tree farming?) YES ☐ NO ☐

If yes, what farm did you work on? Where? _____ When? _____

If you can answer YES to BOTH of the above questions, your family MAY qualify for Migrant Education services. To be contacted by a Migrant Education recruiter, please complete the information below.

Child's name _____ D.O.B. _____ Grade _____

Child's name _____ D.O.B. _____ Grade _____

Child's name _____ D.O.B. _____ Grade _____

Child's name _____ D.O.B. _____ Grade _____

Parents/ Guardians

Mother's name _____ Father's Name _____

Home Address _____ Home Phone # _____
(Street Address)

Work or Message # _____

(city, town or village) (Zip)

School District _____ School Building _____

School Contact Person _____ Contact Number _____

Other Useful information (directions, farm names, best time to contact, etc.) _____

_____

_____

To submit this referral please fax to the Herkimer BOCES at (315) 867-2087 or mail to the address above. For more information please call the Migrant Program at (315) 867-2079. Thank you for your assistance.

Herkimer-Fulton-Hamilton-Otsego BOCES
Migrant Education Tutorial & Support Services
Mary Kline, Migrant Education Director

352 Gros Boulevard
Herkimer NY 13350
315-867-2079

Cuestionario de Elegibilidad para Servicios de Educación Migrante

*** Servicios del Programa de Educación Migrante son gratuitos y pueden incluir tutoría, ayuda con necesidades de salud, viajes educacionales, programas del verano, actividades de involucrar a los padres, educación para adultos, ayuda de emergencia y referidos a otros servicios como necesario. ***

¿Ha mudado su familia a un distrito escolar diferente en los últimos 3 años? Sí ☐ NO ☐

¿En los últimos 3 años ha trabajado un padre o guardián en granja como: lechería, plantando, cosechando frutas o legumbres, el procesamiento o empacar de comida, corta de árboles o cultivo de árboles? Sí ☐ NO ☐

Si UD dijo que si, ¿en que granja? ¿Donde? ¿Cuándo?




Si Usted contestó que Sí a AMBOS preguntas de arriba, su familia PUEDA calificar para servicios de Educación Migrante. Para estar contactado por una reclutadora del Programa de Educación Migrante, favor de llenar la información de abajo.

Nombre del niño(a) _____ Fecha de Nacimiento_____Grado____

Nombre del niño(a) _____ Fecha de Nacimiento _____Grado

Nombre del niño(a) _____ Fecha de Nacimiento _____Grado_____

Nombre del niño(a) _____ Fecha de Nacimiento _____Grado__ __

Padres/ Guardianes

Nombre de la Mamá Nombre del Papá __

Dirección de la Casa _____ Numero de teléfono en casa_____
(Dirección de la Calle)

_____ # de teléfono del trabajo o de Mensaje_____
(Ciudad o Pueblo) (Código Postal)

Distrito escolar __ _____ edificio escolar ____

Persona para contactar_____ numero para contactar _____

Otra información Útil (direcciones, nombres de granjas, mejor hora de llamar, etc.) _____

_____

_____

Para someter este referido, favor de mandarlo por fax al Herkimer BOCES a (315) 867-2087 o mandar por correo al dirección de arriba.
Para más información, favor de llamar al Programa Migrante a (315) 867-2079. Gracias.

BETHLEHEM CENTRAL SCHOOL DISTRICT

BCSD STUDENT BUS REGISTRATION FORM 2024-25

Please fill out the Student Bus Registration Form to indicate your child's **general bus transportation needs** for the 2021-22 school year below.Eligibility for bus transportation at BC has not changed.

Your child is eligible for school bus transportation if:

- **ELEMENTARY SCHOOL:** All children
- **MIDDLE SCHOOL:** More than 1/2 mile from school
- **HIGH SCHOOL:** More than 1 mile from school

Important: If you have a child entering grade 6 or grade 9, please be aware that they may not be eligible for transportation based on the criteria listed above.

Thank you for your cooperation.

STUDENT NAME _____ DOB _____

STUDENT'S PRIMARY ADDRESS _____

SCHOOL _____ GRADE _____

MORNING (TO SCHOOL)

☐ YES, my child is eligible for transportation and WILL need transportation in the a.m.
☐ NO, my WILL NOT need transportation in the a.m.

AFTERNOON (FROM SCHOOL)

☐ YES, my child is eligible for transportation and WILL need transportation in the p.m.
☐ NO, my WILL NOT need transportation in the p.m.

Please note: Students at BCHS and BCMS who participate in afterschool activities will still be able to take the late afternoon transfer buses that run during the school year even if that student does not need regular afternoon transportation from school.

ADDITIONAL INFORMATION REGARDING STUDENT TRANSPORTATION

- Information provided above will be entered in Aspen, the district's Student Information System (SIS). Information can only be changed by request of a parent or guardian.
- If you answer “no” to either question listed above, your child will still be able to request transportation at a later date, if they meet the eligibility criteria listed above.
- To request a transportation change for your child, please email the BCSD Transportation Department at transportation@bethlehemschools.org. Please allow up to two (2) business days for confirmation of the change request.

PARENT/GUARDIAN SIGNATURE _____ DATE _____

Date Mailed/Faxed/Emailed:

Bethlehem Central School District
Office of the Registrar
Educational Service Center
700 Delaware Avenue
Delmar, New York 12054
(518) 439 –2442
(518) 475-0352 FAX

Authorization for the Release or Transfer of Information

Student Name:_____

Name and address of school last attended:

School:_____

Address:_____

_____

Phone and /or Fax:_____

The above student has enrolled in our school district**. Please forward all school records including health, psychological, discipline including records of suspension, academic and other data.** Thank you for your assistance.

SEND TO:

Bethlehem Central School District
Office of Central Registration
700 Delaware Avenue
Delmar, New York 12054
(518) 439-2442
(518) 475-0352 fax
Email: mhaas@bethlehemschools.org

_____ _____

Signature of Parent or Guardian Date